Remarks of
Henry A. Waxman, Chairman
Subcommittee on Health and the Environment
before the
House Budget Committee
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Mr. Chairman and Members of the Committee, I appreciate the opportunity to appear before you today to discuss health care programs and the FY 93 Budget Resolution.

The message I want to leave with you is this:

* the Resolution must reject the Administration's call for a cap on Medicare and Medicaid;

* the Resolution must reject the Administration's request for yet more program cuts in the Medicare;

* the Resolution must provide for new resources to pay for preventive Medicaid initiatives, including the President's 1988 promise to cover all pregnant women and infants up to 185 percent of the poverty level;

* the Resolution must at an absolute minimum provide full inflation adjustments for high-priority discretionary health programs for those with low-incomes; and

* the Resolution must provide additional discretionary funding above inflation for programs relating to childhood immunizations; tuberculosis control; sexually transmitted disease control; lead poisoning prevention; AIDS efforts; and the National Health Service Corps.

Entitlement Caps. As you well know, Medicare and Medicaid outlays are increasing, and are growing as a share of the Federal budget. I recognize that, from your vantage point, these spending increases greatly complicate your efforts to reduce the deficit. But I would urge you in the strongest terms to resist Mr. Darman's call for arbitrary caps on Federal spending for these programs.

The Darman approach will simply shift costs from the Federal government to beneficiaries, employers and workers, and States. The tighter the caps, the greater the shift. Caps on Federal spending won't get at the real source of the Medicare and Medicaid cost problem: health care inflation.

Getting a handle on health care costs will take something much different than a cap on Medicare and Medicaid alone. It will take across-the-board controls on the growth in public and private health spending, such as more uniform payment policies for all purchasers.

Let's be clear about this. Mr. Darman's entitlement cap would ultimately lead to rationing of services to the elderly and the poor. If the real problem here is health care cost inflation -- and it is -- then we need a comprehensive attack on the health care cost problem, not an assault on Medicare and Medicaid. This, of course, was missing from the President's budget and from the President's so-called "comprehensive" health reform proposals.

Medicare

The President's FY 93 Medicare budget includes a series of legislative proposals to cut payments for covered services and to increase the health costs of program beneficiaries. It would violate the Budget agreement by calling for further Medicare reductions. It would raise Part B premiums for certain individuals, undermining the social insurance aspect of the Medicare program. And it calls for additional cuts in payments to both doctors and hospitals in the program.

For the most part, these proposals have been included in prior budget submissions and have been rejected by the Congress. After more than a decade of significant Medicare outlay reductions and growing concern about the impact of these reductions on the quality and accessibility of services to the elderly and disabled, I believe that additional outlay reductions -- absent more explicit evaluation of current policies -- are not warranted.

Let me also mention briefly a serious and continuing problem affecting low-income Medicare beneficiaries. Several years ago when Congress increased Part B premiums, we also expanded financial protection against out-of-pocket costs for low-income beneficiaries. Unfortunately, the Qualified Medicare Beneficiary (QMB) program -- as it is known -- has thus far provided only very limited protection for the elderly poor. Less than one-half of those eligible have been enrolled. Little has been done to inform beneficiaries or to facilitate their enrollment. Of course, there has been no delay in implementing the higher cost-sharing requirements right on schedule: monthly premiums now stand at $31.80.

In the odd budget world in which we live, implementation of the law will be scored as an increase in Federal spending. While I am unable to give you a specific figure at this point, I would urge that the resolution make the necessary resources available for this activity. We in the Congress increased the cost-sharing burden on the elderly, and we have an obligation to see to it that the protections for the poor actually work.

Medicaid

The first message I want to leave with you is that the FY 93 budget resolution should do no harm to Medicaid beneficiaries. That means rejecting the President's proposal to require nursing homes to pay the costs of Federal and State inspections to ensure that quality standards and safety requirements are being met. This ill-conceived proposal was rejected by the Congress in 1990 and again in 1991. It deserves the same treatment this year.

My second observation about the President's Medicaid budget is that it fails to honor his own promise to reduce infant mortality by extending Medicaid coverage to near-poor pregnant women and infants. In October, 1988, then-candidate Bush promised to support extending Medicaid coverage to pregnant women and infants with incomes up to 185 percent of the Federal poverty level--about 175,000 pregnant women altogether. To continue to leave these women uninsured, as the President's budget proposes, would be the height of fiscal irresponsibility.

The President's budget fails to include other modest improvements in the Medicaid program. I would urge this Committee to direct that additional resources be made available to pay for the following preventive initiatives:

o The Medicaid Infant Mortality Amendments, H.R. 1391,

o The Medicaid Child Health Amendments, H.R. 1392,

o The Medicaid Breast and Cervical Cancer Prevention Amendments, H.R. 1393,

o and the Medicaid AIDS and HIV Amendments, H.R. 1394,

I should point out that each of these amendments is paid for completely with Federal funds, offering the States some relief in their Medicaid budgets, and putting us on the path to the Federalization of the entire Medicaid program.

Discretionary Spending

Let me turn now to the discretionary health programs. The President's election year Budget finally contains proposals for some improvements in health care services for the poor: there are increases for the community and migrant health centers, for health care for the homeless programs, and for the National Health Service Corps. I would encourage this Committee to accept its recommendations on these programs as a minimum standard.

One program where more funds are needed is the National Health Service Corps, which provides primary care practitioners in rural and urban areas that are otherwise underserved. The NHSC is currently 4,300 primary care practitioners short of what would be needed to provide services to identified underserved areas. The President has proposed funds sufficient to pay for 495 multi-year scholarships. To increase this number to 1,000 -- barely one-quarter of what is needed -- an additional $25.2 million would be required.

While some of the Administration's health care services proposals move in the right direction, there is a distressing familiarity in some of the funding patterns for public health programs with those under the Reagan Administration. There is a cycle of penny-wise and pound-foolish budgeting, of postponing preventive measures until they are acute problems--and it is inefficient and destructive.

For example, for years during the Reagan Administration, the childhood immunizations program was inappropriately limited, so limited that Federally-assisted efforts were gradually reduced to paying only for vaccine and not for the nurses and public health workers that actually deliver the shots. The result was predicted years ago. Experts came before the Health Subcommittee to say that there would be an outbreak of infectious disease, and that's precisely what has happened: there is now an epidemic of measles among young children in the U.S. At long last, after needless childhood illness, some deaths, and millions of dollars for acute care, the Bush Administration has come forward to say we need an expanded immunization program.

Likewise, for over ten years, the Health Subcommittee has pursued tuberculosis control programs. In years past, the Administration has proposed freezing or complete elimination of the program and has succeeded in limiting its funding. But now, in the midst of an epidemic of TB that experts project will cost hundreds of millions of dollars to treat, the Bush Administration proposes belatedly that we expand TB control.

The same story can be told for lead screening and for hypertension control. The Administration has resisted efforts to deal with the problems early on and now recognizes how large the need has grown. Next year perhaps the same story will be told for venereal disease control. And AIDS prevention.

But I appeal to this Committee not to put the Nation through the same harsh lessons again. We already know that an ounce of prevention is worth a pound of cure. We already know that screening and early treatment are cheaper and more effective than acute care. I would ask you to look carefully at preventive health programs and outpatient primary care and basic and applied research. Without appropriate investment in these efforts, we will be saddling tomorrow's taxpayers with something more than a budget deficit; we will also be giving the next generation a health deficit of unnecessary illness and high treatment costs, illness and costs that we could.

AIDS Efforts. Last year the President and the Congress shortchanged AIDS preventive health services. We cannot do so again. Programs are needed to lower infection among racial and ethnic minorities, among women who are sexual partners of drug users, and among adolescents. Without such programs, the epidemic will spread as surely as if the blood supply were still infected.

Without early preventive services, infected people will become acutely ill and require expensive inpatient care when outpatient care would have allowed them to be productive and free of illness.

If Americans are moved by Magic Johnson, the Federal government should respond by providing information and services that Americans are ready to use. If Americans become blase about AIDS, the Federal government should lead in the creation of a sense of urgency. The Bush Budget does neither.

The President's budget also fails to provide for treatment initiatives for people with AIDS and with AIDS-related illnesses. Adequate funding is not provided for recently authorized programs of early intervention services for people with AIDS, for emergency assistance to high-incidence cities, and for block grant assistance to States. While I believe that comprehensive reform of the Medicaid program's elgibility policies will be necessary as part of AIDS treatment policy, funding of Ryan White is a strong first step.

Even more fundamentally, the President's budget fails to include adequate funding for basic and applied research on the AIDS epidemic, including such crucial projects as the development of preventive vaccines, the development of therapeutic drugs, the development of early intervention drugs for both immune deficiency and accompanying infections, and the study of AIDS in children, women, and racial and ethnic minorities.

As part of its budget proposals for FY 1993, the NIH requested approximately $320 million more than the President's Budget. In this area, as in the other discretionary spending I have described, budget restrictions this year will simply mean multiplied budget demands in future years. Accelerated research efforts could save billions in acute care costs.

Health Care Reform

In closing, I want to stress one additional point. It is obvious to all of us that our health care system is broken and needs to be fixed. Many Americans have access to the best medical care in the world. However, about 15 percent of our nonelderly population, including over 9 million children, have no public or private health care coverage whatsoever. As the recession continues, the number of uninsured Americans is likely to grow. The costs of health care are exorbitant and rising rapidly. The small business health insurance market is deteriorating, leaving many small employers and their employees without the opportunity to purchase affordable coverage.

The solution to these problems will have to be comprehensive. Given the complexity of our health care system, we will have lots of decisions to make. Do we follow an employment-based approach, as recommended by the Pepper Commission, or do we adopt the Canadian model, as other colleagues have proposed? How can we effectively contain health care costs without compromising access to needed, quality care? Whatever path we choose to reform, one thing, is clear: we will need to put new Federal resources into any public program we design. Otherwise, the program simply will not be able to pay for basic health care services for those who turn to it for coverage.

As you evaluate the various requests for resources, you should keep in mind that putting more Federal funds into the Medicaid program will be a requisite for broader reform. The Medicaid program as currently funded is not adequate to the task of providing basic health care services to the 30 million poor people for whom it is now responsible, much less to the over 36 million additional uninsured Americans that it does not now reach. In my view, the acute care portion of the program needs to be Federalized and separated from the welfare system, and reimbursement for basic health services needs to be substantially upgraded. Whether we decide to create a public program that fills in the gaps left by an employment-based system, or whether we choose to establish a universal public program, a restructured, adequately funded Medicaid program will be an essential element of reform.

Earlier this month, the President announced what he characterized as a "comprehensive" health reform plan. It won't control health care costs, and it won't guarantee basic coverage to all Americans. But perhaps its worst flaw is in the financing: the President apparently plans to pay for the tax vouchers by reducing Federal spending on Medicare and Medicaid. This is absolutely unacceptable. Health care reform needs to be paid for in a progressive, broad-based way -- not by taking resources away from the elderly and the poor.